MSM and the Global HIV/AIDS Epidemic: Assessing PEPFAR and Looking Forward

The U.S. response to global HIV/AIDS has had an enormous positive impact in countries around the world hard hit by the epidemic. Under the President's Emergency Plan for AIDS Relief (PEPFAR), the U.S. government has committed nearly $32 billion to bilateral HIV/AIDS programs, the Global Fund to Fight AIDS, Tuberculosis and Malaria, and bilateral tuberculosis programs1 in 88 countries worldwide.2 U.S. investments have directly supported antiretroviral treatment (ART) for more than 2.4 million individuals and care for nearly 11 million affected by the epidemic.3

In spite of these unparalleled resource commitments and the substantial progress that has been made in low- and middle-income countries, HIV/AIDS-related services remain out of reach for the vast majority of men who have sex with men (MSM). In almost all regions, MSM have significantly higher rates of HIV infection than the general adult population—in low- and middle-income countries they are 19 times more likely to be infected with HIV4 Yet only one in 10 MSM worldwide has access to lifesaving HIV/AIDS prevention and treatment services.5

Stigma and discrimination have fueled the neglect of MSM and other vulnerable populations, including injection drug users (IDUs), sex workers, and transgender individuals. The inclination of governments and donor agencies to favor general population strategies over targeted interventions—even when the epidemic is concentrated within vulnerable groups—has exacerbated the severity of the epidemic among MSM.

A global wave of homophobic rhetoric and violence is further undermining efforts to combat high rates of HIV/AIDS among MSM. Many countries criminalize and persecute men who are perceived to be homosexual, making it dangerous for them to access healthcare and HIV services. A recent report by the United Nations Development Programme revealed that more than 90% of MSM in the Asia-Pacific region do not have access to HIV prevention and care because of discriminatory laws.6 Even in settings where same-sex sexual behavior is not prohibited by law, MSM are still subject to harassment and violence.

Key Points

- MSM are 19 times more likely to be living with HIV than the general population in low- and middle-income countries, but only one in 10 MSM worldwide has access to HIV services.
- Stigma, discrimination, and laws criminalizing sex between men undermine access to HIV/AIDS and other health services for MSM.
- Grassroots, community-based groups are at the forefront of emerging efforts to provide HIV services for MSM worldwide.
- Governments and international donors, including PEPFAR, have seriously neglected the HIV epidemic among MSM; services to effectively address the epidemic among this population remain wholly inadequate.
- PEPFAR and other U.S. government programs have considerably expanded HIV/AIDS services for MSM in the last several years.
- The U.S. government and other donors can build on recent progress by: increasing investment in community-based services; supporting scale-up of community-led initiatives; improving epidemiologic tracking; monitoring access to services; and leveraging influence to encourage reform of laws criminalizing same-sex sexual behavior.
Enormous opportunities exist for international donor programs, including PEPFAR, and for governments in affected countries to complement and augment grassroots efforts.

While many barriers to HIV services for MSM are situated at the country level, PEPFAR’s original authorization in 2004 imposed requirements on resource allocation that for years hindered HIV prevention efforts among vulnerable populations. In the last two years there have been notable advances, including a significant expansion in PEPFAR-supported MSM programming and important commitments from PEPFAR leadership in Washington. Still, as this analysis shows, HIV/AIDS services through PEPFAR and other providers remain inadequate to address the epidemic among MSM. Severely lacking are interventions to tackle the formidable social, religious, legal, and policy barriers that stand between MSM and access to HIV health services.

Grassroots, community-based organizations remain at the forefront of vibrant, emerging responses, leading efforts to provide urgently needed HIV/AIDS services to MSM and other vulnerable groups throughout the world. But enormous opportunities exist for international donor programs, including PEPFAR, and for governments in affected countries to complement and augment these efforts. By doing so, they can make important strides against the AIDS epidemic and significantly strengthen global health programming.

KE Y FIND INGS ON THE MSM EPIDEMIC AND HIV/AIDS PROGRAMMING IN PEPFAR COUNTRIES

This issue brief provides a detailed analysis of PEPFAR’s response to MSM in eight countries: China, Côte d’Ivoire, Guatemala, Jamaica, Malawi, Ukraine, Vietnam, and Zambia. The eight countries represent a range of epidemiologic, geographic, and contextual landscapes. The analysis is based on publicly available documents and interviews with U.S. government staff, public health experts, healthcare and service providers, and members of civil society. It combines available data and estimates in journal articles and government reports with information from interviews to develop the most accurate assessment possible. The research reveals some of the challenges faced by global funders in providing services, as well as the paucity of MSM programming in some of the most severely affected countries in the world. The country profiles also offer numerous examples of expanded investment in services and promising new initiatives.

Striking limitations exist in the quantity and quality of available information, including HIV prevalence among MSM and details on targeted program and service availability. In national statistics and some country-level PEPFAR data, MSM are often subsumed under the general category of “most-at-risk populations,” making it difficult to determine which services are targeting MSM specifically.

While the AIDS epidemic and PEPFAR’s responses are different in each of the eight countries, several overarching themes emerge from this analysis:

- **High infection rates:** Where estimates are available—and often little research has been conducted—HIV prevalence among MSM is very high. In all eight countries reviewed, HIV prevalence is significantly higher among MSM than the general population (see Figure 1). This is true even in generalized epidemic settings such as Malawi and Côte d’Ivoire, where HIV prevalence among MSM is reported to be as high as 21.4% and 18.5% respectively.

- **Incomplete epidemiologic data:** In many countries, epidemiologic data on MSM are nonexistent, out of date, or inconclusive. In Côte d’Ivoire and Zambia, for example,
small sample sizes compromise the value of existing data. Many governments do not include MSM in routine HIV/AIDS surveillance and do not systematically gather or report data on MSM as a discrete group. None of the countries profiled officially tracks HIV incidence or HIV exposure risks among MSM—although most report results from sentinel studies in the 2010 UNGASS reports. While PEPFAR is supporting several research studies, for example in Côte d’Ivoire and Malawi, lack of funding and political will undermine efforts to strengthen surveillance mechanisms that would improve understanding of HIV prevalence among MSM.

- **Limited service coverage for MSM:** Of the $2.2 billion spent in the eight countries between FY 2004 and FY 2009, the amount dedicated to MSM-specific interventions is indeterminate. PEPFAR does not report specifically on program financing that targets MSM, and tracking the flow of resources from U.S. agencies through the various funded organizations has proven to be extremely difficult. Still, key informants consistently remarked on the limited availability of HIV-related services for MSM in all countries surveyed here. It is also clear that in some settings, progress has been made through PEPFAR-funded and community-led activities, for example in China, Côte d’Ivoire, Ukraine, and Vietnam. Progress is being made in other countries not examined in this report. In Nigeria, for example, Heartland Alliance has launched a USAID-funded integrated MSM HIV prevention program. In the eight countries examined here, community-based organizations are operating on the front lines of the AIDS pandemic, serving the HIV-related needs of MSM and other vulnerable groups.

Although this issue brief does not examine transgender-specific programs, research suggests that service coverage for this population is extremely limited. Studies indicate that transgender communities in many settings are particularly vulnerable to HIV, and scale-up of HIV related services for these communities is needed. 

- **Widespread criminalization and severe punishment:** Stigma, discrimination, and criminalization are major barriers limiting provision and uptake of HIV services for MSM. Three of the eight countries examined have laws criminalizing homosexuality. Consensual male-to-male sex is punishable by up to 14 years imprisonment in Malawi and Zambia, and by imprisonment and hard labor for up to 10 years in Jamaica. All told, laws prohibiting same-sex sexual activity between consenting adults are on the books in more than half of the countries with PEPFAR programs, including three that impose the death penalty (Mauritania, Sudan, and Yemen). Even in countries without criminal penalties—such as China, Guatemala, and Ukraine—denial of full and equal rights for MSM and other sexual minorities exacerbates HIV risk by driving MSM underground and beyond the reach of HIV information and health services.

- **Civil society as a driving force for change:** In all of the countries examined here, community-based efforts to advance MSM health and rights have been central to the successes that have been achieved. In countries such as Guatemala, Jamaica, and Zambia, local and national governments do not explicitly prioritize MSM in their HIV/AIDS response and dedicate only limited resources for interventions targeting this population. Consequently, the AIDS response has depended on support from donors working in partnership with local nongovernmental organizations (NGOs), MSM-friendly champions in decision-making positions, and civil society. In all countries examined here, many NGOs that serve MSM appear to be highly motivated but need technical support in areas such as fiscal and personnel management, strategic planning, and the provision of basic public health information.

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REACHING MSM: RECOMMENDATIONS FOR PROVIDERS AND GOVERNMENTS

The urgency of scaling up HIV programs to reach MSM is widely recognized, even as programmers and funders struggle to implement long-overdue interventions. Because the HIV/AIDS epidemic and the cultural, political, and economic forces that shape it are unique to every country, no two national responses can be exactly the same. Funders and program implementers need to be flexible in their approaches to local epidemics and social contexts. Nonetheless, research and direct experience point to a series of recommendations that are broadly applicable to HIV/AIDS funders and policy makers.

Global institutions such as the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the World Health Organization (WHO) recommend that certain core components be included in a comprehensive package of services for MSM: 12-13,14,15,16

- **MSM peer outreach** and engagement in HIV care and treatment services;
- **Trained health providers** with the specific knowledge, attitudes, and skills necessary for working with MSM, along with clinics that are MSM-friendly (with confidential intake, record-keeping, and follow-up);
- **HIV/sexually transmitted infection (STI) diagnostics** at clinics serving MSM, including rapid tests for HIV and syphilis, screening for gonorrhea, and Pap smears to screen for anal dysplasia;
- **Immunizations** against hepatitis A, hepatitis B, and human papilloma virus;
- **Promotion and distribution of water-based lubricants and condoms**; and
- **Supportive interventions that include capacity building, community mobilization, stigma reduction programs, income-generating activities, and advocacy for legal/policy reform and human rights protections.**

Without MSM-specific HIV/AIDS services, MSM and transgender people can receive HIV services only through general health services. But many MSM are reluctant to disclose their sexual activities to healthcare workers who are untrained on MSM sexual health issues, limiting their access to HIV prevention interventions, voluntary HIV testing, and other recommended health services. 17 Governments and donors have a responsibility to assess the degree to which government-run health facilities are able to meet the needs of MSM and other vulnerable populations. In some cases, community-based NGOs are better positioned to deliver services to MSM than government agencies. In others, clients may prefer to obtain services from public health systems.

**RECOMMENDATIONS TO ADVANCE PEPFAR PROGRAMMING**

PEPFAR’s recent efforts to address HIV among MSM have been limited but hold substantial promise. Legislation reauthorizing PEPFAR in 2008 recognized the importance of addressing the HIV service needs of MSM, calling for “appropriate HIV/AIDS education programs and training targeted to prevent the transmission of HIV among [MSM].” 18 PEPFAR’s Five-Year Strategy, released in December 2009, acknowledges the disproportionate impact of HIV on MSM and notes that governments are “often reluctant to engage in outreach to these communities.” The strategy pledges to address stigma and discrimination against MSM and to support targeted HIV prevention and treatment services. 19

Based on the PEPFAR country analyses in this report, a number of recommendations can be made for actions to strengthen this nascent response. With the epidemic

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**In Malawi, a Matter of Life and Death**

Stigma and discrimination toward MSM are on the rise in Malawi, driven in part by the case of two men who were arrested in late 2009 after publicly celebrating their engagement. Despite a presidential pardon in May 2010, the arrest, trial, and imprisonment of Steven Monjeza and Tiwonge Chimbalanga have generated widespread fear among MSM seeking health services and organizations that provide those services. In February 2010, the Center for the Development of People (CEDEP), which provides HIV testing, counseling, and outreach to MSM and other vulnerable groups in Malawi, was forced to close its office in Blantyre and relocate to the capital, Lilongwe, after two health workers from the organization were arrested. With the flare-up of homophobia in Malawi, CEDEP is facing new challenges in scaling up HIV/AIDS-related interventions for MSM.
Governments and donors have a responsibility to assess the degree to which government-run health facilities are able to meet the needs of MSM and other vulnerable populations.

among MSM continuing to expand, PEPFAR and the Obama administration’s Global Health Initiative must take the following concrete steps to more effectively reach MSM and vulnerable populations:

1. Create an MSM-specific strategic fund to provide resources for PEPFAR countries beyond their baseline allocations. This fund should support research in countries with limited data, refinement of MSM population size estimates, and scale-up of proven cost-effective programs in countries with existing programs such as China, Ukraine, and Vietnam.

2. Substantially increase financial support for community-based MSM groups and NGOs to provide HIV services to MSM and advocate for human rights. Beyond program support, funding should be dedicated to developing organizational capacity for front-line community groups, including core development such as fiscal and personnel management, strategic planning, and computer and social media training.

3. Develop policies to guide expansion and uptake of a comprehensive package of health services tailored to the needs of MSM, both through general health systems and targeted initiatives that can be accessed by people who may not feel safe using general health services. In many cases, NGOs will be better positioned to deliver services to MSM than government-run public health settings.

4. Provide training and guidance to help providers in local health sectors respond to the specific needs of MSM and offer appropriate services. Training should also be conducted for all U.S. government health and development staff, implementing partner agencies (both global and local), and key stakeholders.

5. Help national AIDS control agencies and health ministries understand and prioritize the health needs of MSM using PEPFAR Partnership Frameworks, Partnership Framework Implementation Plans, and other agreements between the U.S. government and PEPFAR countries. Governments should prioritize strengthening surveillance to more closely track HIV among MSM, and to improve understanding of the social and behavioral risk factors that should inform programming.

6. Appoint an MSM coordinator at the Office of the Global AIDS Coordinator (OGAC) to track and report MSM-specific PEPFAR programming, budget allocations, and policy and program outcomes. The MSM coordinator should provide timely, detailed, and comprehensive information on the budgeting, delivery, and monitoring of PEPFAR-supported MSM programs. PEPFAR should make these data publicly available.

7. Increase financial and technical support for operations research that can identify interventions capable of reaching diverse MSM communities in different countries, and disseminate results to inform national and regional policies.

8. Work with national governments, civil society coalitions, and multilateral partners including European governments, UN agencies, the World Bank, and the Global Fund to increase global resources for HIV/AIDS and related programs targeting MSM, and facilitate the direct and meaningful involvement of MSM in global and national decision-making bodies.

9. Address the unique vulnerability of transgender people by expanding research and targeted HIV interventions for this population.

10. Use diplomatic and financing leverage to encourage recipient countries to identify policy changes that impede effective HIV programs; repeal laws that criminalize consensual adult same-sex sexual practice; and reform policies that fuel stigma and discrimination.
MSM AND HIV IN EIGHT PEPFAR FOCUS COUNTRIES

The country profiles that follow provide an overview of the most recent information available about the status of MSM in relation to the fight against HIV in eight PEPFAR countries. This analysis reviews the best available epidemiology, provides a snapshot of PEPFAR-supported services for MSM, notes the legal status of male-male sexual behavior, and summarizes priorities for improving the HIV response. The information on programming is based on a broad range of sources, including publicly available documents such as:

- 2008 and 2009 PEPFAR Country Operating Plans (COPs)
- Partnership Framework Agreements
- Partnership Framework Implementation Plans
- 2010 UNGASS country progress reports
- Peer review and public health literature.

In addition, 23 interviews with key informants were conducted between April and June 2010 by amfAR staff in Washington, D.C., including:

- Field-based PEPFAR staff from USAID and the Centers for Disease Control and Prevention (CDC)
- Country and program managers for major PEPFAR-supported NGOs
- Leaders from front-line community groups operating in each of the eight countries
- Leading epidemiologists and experts on MSM issues.

CHINA

Snapshot of the epidemic
With a 0.057% HIV prevalence among the general population, China is experiencing a low-prevalence epidemic, with higher prevalence in some regions. At the end of 2009, an estimated 740,000 people were living with HIV, of whom 48,000 were newly infected.

Estimates from 2009 indicate that heterosexual transmission accounted for 42.2% of new infections and male-male sexual transmission, 32.5%. The latter figure represents a significant increase over 2007, when male-male transmission accounted for 12.2% of new cases. A 2008 national MSM epidemiological survey carried out in 61 major cities reported an overall HIV prevalence of 5%, but HIV prevalence among MSM varies considerably in different parts of China. Estimates range from 1.5% in Shanghai, to 5% in Shenzen, 8.5% in Chongqing, and 9.1% in Chengdu. More recent studies have shown HIV incidence rapidly increasing among MSM in China, including Nanjing, where a study reported an incidence of 5.12 per 100 person-years.

Legal status
China does not criminalize homosexual activity. However, laws in China do not bar discrimination or specifically protect MSM and other sexual minorities, which is a reality that presents a barrier to program scale-up in certain areas, according to key informants.

Budget
PEPFAR-approved FY09 funding for China is $10.3 million. Since 2004, PEPFAR has invested nearly $40 million to support HIV programming in China. Financial information on MSM-specific programming is unavailable.

Interventions
China’s post-SARS leadership is alert to the pitfalls of neglecting the country’s public healthcare system. The government’s change in attitude has ushered in increased spending on public health and improved HIV-related policies. Government funding was mobilized specifically for MSM in 2004 and again in 2007, when MSM were added to China’s national strategic framework.
PEPFAR’s involvement has intensified in recent years, including support for a national MSM epidemiological survey and the development of a “minimum package of services” model for MSM. PEPFAR has also supported MSM-friendly STI clinics and the development of a model for clinic-based peer-driven behavioral interventions addressing STIs in Beijing, Heilongjiang, and Shandong. Capacity building with local partners has involved training local sub-partners, including community-based groups and other grassroots NGOs, in behavior change interventions, HIV prevention, and working with at-risk populations. In Anhui, Beijing, Heilongjiang, Jiangsu, Shandong, and Yunnan, where HIV prevalence among MSM is growing, the U.S. supported the development of self-help groups among HIV-positive MSM networks, which helped to develop web-based support, telephone hotlines, and peer support services.

While the U.S. has a relatively small presence in China’s overall HIV/AIDS landscape, USAID is currently supporting Family Health International (FHI), Health Policy Initiative (HPI)/RTI International, Management Sciences for Health (MSH), the University of North Carolina MEASURE Evaluation program, Pact (through a sub-grant to the International HIV/AIDS Alliance), and Population Services International (PSI), all of which provide sub-grants to local governments and local community-based organizations. PEPFAR also supports the Purple Sky Network, which works to reduce HIV among MSM by strengthening MSM community groups, improving clinical services, and engaging with governments to establish a supportive environment for HIV prevention.

Priorities moving forward
Despite efforts supported by the U.S. and other donors, many MSM in China remain beyond the reach of needed services. HIV interventions reach an estimated 70,000 MSM per month—only around 9% of estimated need. Novel outreach mechanisms such as online resources need to be designed and adopted.

Key informants identified the narrow focus of donor programming and inability to support a wide range of appropriate services as central challenges. Informants stressed the need for donors and program implementers to support a diverse range of options and service delivery mechanisms. Other challenges include increasing the capacity of health providers to identify and manage the sexual health of MSM and increasing financial and political support to build the capacity of community groups and peer education systems.

CÔTE D’IVOIRE

Snapshot of the epidemic
Côte d’Ivoire has a generalized HIV epidemic with an estimated prevalence of 3.7% among adults aged 15 to 49, one of the most severe outbreaks in West Africa. The epidemic is marked by striking gender and geographic differences, with multiple populations identified as high risk including serodiscordant couples, uniformed services and ex-combatants, sex workers, economically vulnerable women and girls, truckers and mobile populations, sexually active youth, and orphans and vulnerable children. The country’s prolonged political-military crisis has probably exacerbated the epidemic among vulnerable groups including MSM, for whom epidemiological data remain extremely limited. To date, there has been no nationwide official study of MSM and HIV. A 2009 study with a sample size of 54 estimated prevalence to be 18.5%.

Legal status
While male-male sexual activity is not prohibited by law, MSM are not able to claim full equal rights, according to key informants interviewed in country. Moreover, stigma, discrimination, and lack of MSM-friendly health staff prevent many MSM from accessing public health services.

Budget
Côte d’Ivoire was one of PEPFAR’s original focus countries. The U.S. remains the largest supporter of HIV/AIDS programs in the country, with $124.8 million approved for FY09. Since 2004, PEPFAR has invested nearly $445 million to support HIV programming, but financial information on MSM-specific programming is unavailable. In February 2010, the U.S. Department of Health and Human Services and the CDC announced a five-year award with a ceiling in the first year of $3.5 million to increase targeted research, capacity building of local organizations, and coverage of HIV/AIDS prevention and care services targeting highly vulnerable populations, including MSM.

Interventions
In 2009, the CDC supported a preliminary study that included interviews and focus group discussions with 32 MSM and eight health service providers in Abidjan. The 2009 COP reports that PEPFAR will complete an assessment of risk behaviors
and seroprevalence among MSM in Abidjan, and “specific communications and interventions for this potential high-risk group will be developed based on early and final results.”

A technical review committee has also been established in country, according to PEPFAR documents, and a working group on highly vulnerable populations, led by the Ministry of Health, is “spearheading the national effort, which includes international organizations, the Ministry of Health, and multiple implementing organizations.”

Côte d’Ivoire has an extensive brothel- and bar-based sex worker population, which has been targeted for prevention services from many PEPFAR implementers, primarily FHI. With PEPFAR support, FHI provides prevention and care services to highly vulnerable populations, working with several national Ivorian NGOs, including Clinique de Confiance, which serves male sex workers. PEPFAR also supports the Johns Hopkins Center for Communication Programs (CCP), which provides technical assistance and support to national ministries and implementing partners, to develop communication tools on HIV prevention and risk reduction messages for MSM.

As reported by U.S. government staff, PEPFAR is funding FHI in 2010 to conduct MSM-related studies in two additional sites beyond Abidjan, and the Global Fund is proposing plans for MSM-related HIV research and services.

Priorities moving forward

Through its support for the government and implementing organizations, PEPFAR has made progress in increasing the visibility of MSM in HIV/AIDS strategic plans. However, stigma and discrimination are widespread, and MSM are unable to access health services. To expand programming, key informants underlined the importance of increasing capacity of local organizations that provide MSM-tailored services and sensitizing healthcare workers in public of health settings. New resources are also needed to bring interventions to scale.

GUATEMALA

Snapshot of the epidemic

With a general population HIV prevalence of less than 1%, the HIV/AIDS epidemic in Guatemala is concentrated among certain vulnerable populations, including MSM. According to Guatemala’s 2010 UNGASS report, transmission is primarily sexual (94%), followed by mother to child (5%). In 2009, there was an average of 17 new HIV infections per day and reports estimated that two-thirds of people with HIV were unaware of their status. According to official statistics, 63% of the 20,484 reported cases of HIV/AIDS are men, a majority of them between 20 and 39 years of age. Migratory work patterns contribute to the spread of Guatemala’s epidemic, which means that the country’s HIV-infected population is concentrated along major transportation routes in urban areas.

National HIV prevalence among MSM is estimated to be 10% but higher in some places, including Guatemala City, where it reaches 18%.

Legal status

Male-male sexual activity is not prohibited by law. However, studies have documented homophobia and transphobia within Guatemalan culture, which cultivates exclusion and aggression towards MSM and other sexual minorities. Strong social pressure to be heterosexual leads many gay and bisexual men to hide sexual identities and behavior from girlfriends or wives. Negative attitudes among healthcare providers towards MSM and other high-risk groups have also been documented. In the first half of 2010, 13 transgender people were murdered in Guatemala.

Budget

Approved PEPFAR funding for Guatemala in FY09 is $3.55 million, which includes $2.05 million in direct bilateral funding and $1.5 million through the Central America regional platform. Since 2004, PEPFAR has invested nearly $15.8 million to support HIV programming in Guatemala. Financial information on MSM-specific programming is unavailable.

Interventions

USAID, through the Central American HIV/AIDS Regional Program (G-CAP), has been involved for several years in addressing the epidemic among vulnerable populations.
through targeted behavior change programs and efforts to improve the treatment and care skills of medical personnel.39 Since 1995, USAID has funded PASC (Central America HIV/AIDS Prevention Program) to provide technical assistance to strengthen and expand the Central American response to HIV/AIDS.40

USAID’s Health Policy Initiative supports efforts to defend the rights of HIV-infected and -affected individuals, including MSM and sex workers.39 PEPFAR also supports the Pan American Social Marketing Organization (PASMO) through PSI to improve prevention services, including those aimed at MSM, through social marketing.

Priorities moving forward
PEPFAR’s modest support for the Central American region is not sufficient to meet the needs of MSM given the lack of funding from other sources for this work. In Guatemala, MSM and other high-risk groups face discrimination that undermines their use of public health services. Interviewees identified the lack of stigma reduction programs for health providers as a key barrier to scaling up HIV and STI prevention services for hidden MSM. U.S. government staff in Guatemala noted the government’s missed opportunity to clearly prioritize MSM in the country’s national AIDS plan, presenting a challenge expanding MSM interventions and epidemiological research in this population. Although MSM are not identified explicitly in the Central American HIV/AIDS Partnership Framework—signed in March 2010 by the U.S. and seven countries in the region, including Guatemala—promising provisions for prevention, health systems strengthening, strategic information collection, and policy-related work are included.46

JAMAICA

Snapshot of the epidemic
Jamaica has both generalized and concentrated epidemics, with an estimated 1.6% of the adult population infected with HIV and much higher HIV prevalence among vulnerable populations such as MSM.47 Approximately 50% of people living with HIV are believed to be unaware of their status and are therefore not accessing appropriate services.11 Behaviors such as multiple sex partners, high levels of transactional sex, and low age of sexual debut—combined with poverty, gender disparities, and homophobia—continue to fuel the transmission of HIV in Jamaica.47

A 2007 survey found that approximately one in three MSM in Jamaica was HIV infected (32%).48 MSM with reportedly low socio-economic status who had ever been homeless and were victims of physical violence were significantly more likely to be HIV positive.48 The 2010 UNGASS report notes that the sexual activity of 40% of men with AIDS is unknown and may reflect an unwillingness to reveal sexual orientation.47

Legal status
Male-male sexual activity is illegal and subject to imprisonment for up to 10 years.23 This perilous legal environment, along with persistent fears among MSM of discrimination and violence, continues to hamper the implementation of services for MSM.47

Budget
In Jamaica, approved PEPFAR funding for FY09 is $1 million.44 Since 2004, PEPFAR has invested nearly $9.38 million in direct bilateral support to the country.44 Financial information on MSM-specific programming is unavailable.

PEPFAR’s support for HIV programming is dwarfed by much larger contributions from the Global Fund and the World Bank. In April 2010, PEPFAR announced the Caribbean Regional Partnership, a five-year, $100 million strategy encompassing 12 countries and two regional organizations.49

Interventions
According to the country’s 2010 UNGASS report, MSM activities have been scaled up since 2008, reaching more than 2,000 men through a combination of outreach work and structured workshop interventions led primarily by Jamaica AIDS Support for Life and the Jamaica Red Cross.47

PEPFAR’s role in Jamaica to date has been very limited, supporting no direct programs targeting MSM. Encouragingly, a 2010–2014 country assistance strategy completed by USAID highlights the reduction of HIV transmission among at-risk populations as a key priority of HIV/AIDS prevention work.20

Priorities moving forward
Underscored by key informants, expanded prevention and care programs that focus explicitly on reducing widespread discrimination are urgently needed in Jamaica. Approximately 3% of MSM in Jamaica have access to HIV programs, according to U.S. government staff. Informants say that reducing stigma and discrimination remains critical for increasing access to these programs, along with sensitizing
stakeholders and building capacity among community partners and local institutions. Social and structural interventions to challenge homophobia and stigma-related violence have also been indicated as critical to program expansion.

MALAWI

Snapshot of the epidemic
HIV prevalence has stabilized at 12% in the 15–49 age group. Although prevalence is higher in urban and semi-urban areas, the majority of HIV-positive people live in rural regions. Official HIV prevalence statistics among high-risk groups in Malawi are slowly emerging. A 2009 cross-sectional study of 537 men in Malawi, Namibia, and Botswana who reported ever having sex with a man revealed combined HIV prevalence of 17.4%. Among study participants in Malawi, prevalence was 21.4%, 95% of whom were unaware of their HIV status. In another report from the same study, a majority of MSM (53.7%) reported having concurrent relationships with both a man and a woman. Further, HIV prevalence was 15.2% among MSM between the ages of 18 and 23; 21.6% among those aged 24–29; and, most notably, 35.3% among those older than 30, suggesting that this is not a new epidemic among Malawian MSM.

Legal status
Male-male sexual activity is punishable by law, with imprisonment up to 14 years. The penal code criminalizes “carnal knowledge against the order of nature,” widely understood to mean anal sex. In May 2010, the president of Malawi pardoned a male couple engaged to be married who had received the maximum sentence of 14 years in prison with hard labor when they were convicted of “unnatural offences” and “indecent practices between males” (see page 4). Interviewees expressed grave concern that this case may continue to have a negative impact on HIV prevention efforts for MSM in Malawi.

Budget
International funding accounts for nearly all (98%) support for HIV/AIDS programming, 71% of which comes from multilateral contributors such as the Global Fund. PEPFAR funding is $43.2 million for FY09, and totals nearly $153 million since 2004. Financial information on MSM-specific programming is unavailable.

Interventions
Despite the high HIV prevalence among MSM in Malawi, there is no national HIV/AIDS programming targeting this high-risk group, supported by the Malawian government or other stakeholders including PEPFAR. With USAID funding, PSI in Malawi contracted the Center for the Development of People (CEDEP) to undertake formative research on MSM as part of the Evidence-Based Targeted HIV Prevention (EBT Prev) Project – Dwangwa Pilot Project.

Supported by the evidence generated by CEDEP and colleagues, the National HIV Prevention Strategy of the Republic of Malawi: 2010-2013 identified MSM as one of many most-at-risk populations. According to the 2009 partnership framework between Malawi and the U.S., PEPFAR will focus on reducing new HIV infections, improving the quality of treatment and care, and supporting systems needed to achieve these goals. Although Partnership Framework activities mention targeting high-risk groups, interventions targeting MSM are not explicitly declared.

Civil society groups remain the primary providers of MSM-related programming and outreach activities in Malawi. Research 2 Prevention (R2P), a USAID-funded project led by the Johns Hopkins Center for Communication Programs and CEDEP, plans to investigate effective interventions for preventing the spread of HIV among MSM in 2010.

Priorities moving forward
Many HIV service providers have serious concerns about breaking the law when providing services to MSM, according to key informants. Similar fears about Malawi’s laws may also explain why many MSM do not feel comfortable accessing public health services. Key informants identified the following priorities for expanding HIV services targeted to MSM: expanding MSM-friendly programs and specialized health centers; sensitizing public health service providers; and creating an enabling legal environment for intervention activities.
UKRAINE

Snapshot of the epidemic

The expanding HIV epidemic in Ukraine continues to be concentrated among IDUs, sex workers, and MSM, the majority of whom are unaware of their HIV status. Adult HIV prevalence is estimated at 1.63%, the highest rate of any country in Europe.

Surveillance data on HIV among MSM are limited. One recent study estimated HIV prevalence among MSM to be 8.6% nationally, and much higher in cities such as Lviv (18.8%), Donetsk (19.9%), and Odessa (21.7%). In general, prevalence and population size estimates among MSM are thought to be under-representative given the difficulty of identifying MSM due to stigma and discrimination. Although evidence suggests that the proportion of MSM who also inject drugs is relatively small, the high HIV prevalence among IDUs (which exceeded 40% in 2007) puts the subset of MSM, albeit small, at very high risk of HIV infection.

Proposed Anti-Homosexuality Bill in Uganda Imperils AIDS Work

In Uganda, consensual sex between adults of the same sex is punishable under law, including imprisonment for seven years or more. The Anti-Homosexuality Bill, introduced in Uganda’s parliament on October 14, 2009, would have imposed a wider range of severe punishments for homosexual acts, including the death penalty for “aggravated homosexuality,” defined as any same-sex sexual activity by people who are living with HIV. The proposed legislation also called for imprisonment for anyone who failed to report individuals engaging in homosexual acts—a provision that would effectively criminalize the efforts of all organizations working in LGBT communities, including those delivering HIV/AIDS prevention, treatment, and care. No matter what the ultimate fate of the proposed legislation, such efforts severely undermine ongoing public health efforts to combat HIV/AIDS among Ugandan MSM, a population at high risk of HIV infection.

Legal status

Ukraine was the first former Soviet state to decriminalize male-male sexual activity. However, stigma and discrimination play a substantial role in limiting HIV testing, disclosure, and use of HIV services by MSM. Key informants describe the lack of non-discrimination laws and protective regulations for MSM as a significant challenge to future program expansion.

Budget

Approved PEPFAR funding for FY09 is $16.7 million, a marked increase over previous contributions. Since 2004, PEPFAR has invested nearly $47 million to support HIV programming in Ukraine. Financial information on MSM-specific programming is unavailable. The Global Fund remains the largest external financing source of HIV/AIDS services, exceeding $45 million in 2007–2008, followed by support from the World Bank and UN agencies.

Interventions

Ukraine’s national program to provide HIV prevention, support, and treatment to people living with HIV/AIDS did not include MSM as a priority group for targeted HIV prevention when enacted in 2004, although a 2008 update explicitly listed MSM. According to interviews, the National Council on HIV/AIDS has no representation from MSM communities. While the 2010 UNGASS report states that 63% of MSM were reached with HIV prevention programs in 2009, program monitoring data are believed to be more accurate and suggest a coverage rate of only 13.5.

USAID involvement has been limited to interventions targeting IDUs and to certain geographic regions. According to the country’s 2009 COP, U.S.-supported efforts have reached more than 13,000 MSM since 2002. Since 2004, USAID has supported the SUNRISE Project, implemented by the International HIV/AIDS Alliance, which supports most-at-risk communities including MSM. As of 2009, the Alliance, which is also supported by the Global Fund, had 17 MSM projects in 16 regions, including four clinics that provide MSM-tailored services.

Priorities moving forward

Additional investments are needed to scale up interventions targeting MSM. Informants identified a variety of priorities that warrant urgent attention, including designing interventions to reach the growing population of MSM over 35 years of age; extending interventions beyond major cities, particularly in western regions that are reportedly more homophobic; sensitizing health providers in public and specialized clinical settings; developing anti-discriminatory laws to support and
protect MSM and other sexual minorities; and supporting capacity building among local community groups, peer support mechanisms, and regional networks.

VIETNAM

Snapshot of the epidemic
The HIV epidemic in Vietnam remains concentrated among IDUs, female sex workers, and MSM.69 Estimated prevalence among adults aged 15 to 49 is 0.5%39 Men accounted for 73.2% of all reported cases in 2009.70 Several studies have tracked prevalence rates among MSM. Regional HIV prevalence estimates from 2006 vary from 9.4% of MSM in Hanoi to 8.0% in Ho Chi Minh City.13 According to more recent surveys conducted in four provinces (Hanoi, Hai Phong, Ho Chi Minh City, and Can Tho), HIV prevalence among MSM is increasing and is now up to 17.4% in Hanoi and 16.7% in Ho Chi Minh City.69,70

Legal status
Male-male sexual activity is not prohibited by law.23 Vietnam still faces considerable barriers in establishing and scaling up effective interventions to reach at-risk populations. Stigma and discrimination are prevalent throughout society and fear of being identified as MSM deters many men from purchasing condoms and lubricant in pharmacies or accessing public health systems.75

Budget
One of the original PEPFAR focus countries, Vietnam has approved funding in FY09 of $89 million.71 Since 2004, PEPFAR has invested nearly $322 million to support HIV programs in the country.71 Vietnam remains heavily dependent on PEPFAR support, which accounted for nearly 90% of bilateral aid and 66% of total national spending on HIV/AIDS in 2008.69 Financial information on MSM-specific programming is unavailable.

Interventions
USAID began supporting HIV/AIDS programs in Vietnam in the mid-1990s. U.S. funds support interventions to prevent HIV transmission among most-at-risk populations, including IDUs and their partners, sex workers, male clients of sex workers, and MSM. USAID implements HIV/AIDS programs through 13 primary and more than 50 sub-partners focused in nine provinces.72

The U.S. funds a number of NGO partners to implement programs targeting MSM, including FHI, Pact (which sub-partners with CARE), PSI, and the University of North Carolina MEASURE Evaluation program.73 PEPFAR also supports UN agencies to increase coordination and advocacy of national and provincial MSM working groups and regional networks such as PSN. Through these partnerships, PEPFAR has supported FHI efforts to measure HIV prevalence among MSM and HIV interventions for MSM in six provinces—Hanoi, Ho Chi Minh City, Hai Phong, Da Nang, Khanh Hoa, and Can Tho.73

PEPFAR supports a range of interventions through its partners, including a condom social marketing program through PSI, and community, peer, and web-based outreach to MSM-friendly entertainment establishments.73 Community-based groups are key partners in service delivery of PEPFAR programs. For example, the Sexually Transmitted Diseases (STDs)/HIV/AIDS Prevention Center is running an FHI-funded male sexual health intervention in Hanoi and, according to interviews, has reached more than 5,000 MSM as of April 2010. Between 2006 and 2008, PEPFAR supported a comprehensive evaluation of community outreach programs for most-at-risk populations, including MSM.74 FHI, with funding from USAID, also conducted a rapid assessment to better understand the underlying personal, social, and environmental reasons for MSM risk behaviors.75

Priorities moving forward
Although considerable progress has been made in Vietnam, prevention coverage for MSM still remains low, limited to only seven of 64 provinces, according to key informants. The following priorities were identified: developing a national strategy to address MSM; sensitizing public health providers to be more MSM-friendly; tailoring care and treatment services to meet unique needs and variations among rural and urban settings; supporting the growth and building the capacity of MSM community groups; and encouraging the direct participation of MSM in decision-making bodies in government.
ZAMBIA

Snapshot of the epidemic
Zambia has a generalized epidemic with an HIV prevalence rate of 14.3% among adults aged 15 to 49.76 Demographic and ecological variables put certain groups at greatest risk of HIV/AIDS.76 Because Zambia has not systematically monitored HIV prevalence in high-risk populations, the country did not report on any of the five MSM-related UNGASS indicators in 2010. The few epidemiological studies that have been conducted have uncovered heightened HIV prevalence among MSM in Africa, including in Zambia, where a 2006 study revealed a self-reported HIV prevalence of 33% among 641 MSM.77

Legal status
Male-male sexual activity is criminalized and subject to penalties, including imprisonment for up to 14 years.23 Although the government of Zambia has acknowledged the need to reconsider criminalization of same-sex sexual activity so that MSM populations can be adequately targeted as a part of the response to HIV/AIDS, recent contradictory statements by prominent leaders and government officials, including the chair of the National AIDS Council in Zambia, have created a climate of fear among MSM, according to leaders of community groups.78

Budget
An original PEPFAR focus country, Zambia receives most of its HIV/AIDS funding from PEPFAR. Approved funding is $270.4 million for FY09, and totals nearly $1.116 billion since 2004.79 Financial information on MSM-specific programming is unavailable.

Interventions
PEPFAR is not currently supporting any MSM-specific services in Zambia. MSM-related HIV services are almost exclusively provided by civil society organizations. PEPFAR’s at-risk population programming focuses on female sex workers. A 2007 CDC-funded proposal to study HIV among MSM was rejected by the University of Zambia Research Ethics Committee. Informants noted that the CDC could have done more to meaningfully engage government officials and civil society partners during the initial planning phases. To date, no formal study has evaluated HIV risk among MSM in Zambia. Friends of Rainka has received private foundation support to conduct an epidemiological probe of HIV among MSM in three urban sites and one rural site in four provinces of Zambia.80

The Zambian National HIV and AIDS Strategic Framework 2006–2010 covers key target populations, including women and sex workers, but not explicitly MSM. However, it does not openly address MSM. Encouragingly, the 2009 National Strategy for the Prevention of HIV/STI acknowledged that MSM constitute a particularly vulnerable risk group for HIV/AIDS and recognized the “urgent need” to include them in national AIDS strategies.81

Priorities moving forward
Homophobia and widespread discrimination are rampant in Zambia. Strengthening community awareness and building the capacity of local partners, stakeholders, and community groups are major challenges identified by informants. For PEPFAR to have a meaningful impact, it must work closely with community groups within the country’s legal framework and place a greater emphasis on highlighting structural factors that can threaten public health and effective responses to HIV/AIDS.

Acknowledgments

amfAR gratefully acknowledges the invaluable contributions of numerous organizations and individuals working on the front lines to combat the HIV/AIDS epidemic among MSM and without whose help and support this report would not have been possible.
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68 Interview with Alliance staff in Ukraine. April 30, 2010.


